

FILED NOV 5 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

34987

State File No. 9103

318 1003

BIRTH NO.		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No.	
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (In this place)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis			
d. FULL NAME OF HOSPITAL OR INSTITUTION 3910 Connecticut St.				d. STREET ADDRESS (If rural, give location) 3910 Connecticut St.			
3. NAME OF DECEASED (Type or Print) a. (First) MARIA		b. (Middle) J.		c. (Last) BURKE		4. DATE OF DEATH (Month) (Day) (Year) Oct. 21, 1949	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow		8. DATE OF BIRTH Nov. 9, 1867	
9. AGE (In years last birthday) 81		IF UNDER 1 YEAR Months 11 Days 12		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Ireland, County Sligo		12. CITIZEN OF WHAT COUNTRY? U.S.	
13a. FATHER'S NAME William Burns		13b. MOTHER'S MAIDEN NAME Ann Kavanaugh		14. NAME OF HUSBAND OR WIFE Late John C. Burke			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME James L. Burke		ADDRESS -3910 Connecticut St.	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardio-vascular--renal disease ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Senility				INTERVAL BETWEEN ONSET AND DEATH 41 yrs.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 1310			
21d. TIME OF INJURY		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 442X			
22. I hereby certify that I attended the deceased from Oct. 14, 1948, to Oct. 21, 1949, that I last saw the deceased alive on Oct. 21, 1949, and that death occurred at 2:00 a.m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title)				23b. ADDRESS 3720 Washington Blvd.		23c. DATE SIGNED 10/22/49	
24a. BURIAL CREMATION, REMOVAL (Specify) Burial		24b. DATE 10/24/49		24c. NAME OF CEMETERY OR CREMATORY Calvary		24d. LOCATION (City, town, or county) (State) St. Louis Mo.	
DATE REC'D BY LOCAL REG. OCT 24 1949		REGISTRAR'S SIGNATURE J. B. Foster		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Kriegshauser-4228 S. Kingshighway Bl			

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

2016

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed

Richard W. Stovesand

Licensed Embalmer No. 4007

P. O. Address _____

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.